Timely Claims Payment - Definition of Claim

Inpatient/Outpatient Hospital, Nursing Facility and Home Health (UB92) - A claim is a paper document or an electronic record requesting payment for services provided during a date range for which there are one or more accommodation revenue codes, HCPCS and/or ancillary codes.

Pharmacy - A claim is each detail line item of a paper document or an electronic record requesting payment for pharmacy services (indicated by NDC codes) provided to a recipient by the billing provider. However, compound drugs are billed on a separate claim form and each of these compound drug claim forms represents a separate claim, the line items on which are the components of a compound drug.

All other claim types - A claim is an individual line item on a paper document or electronic record requesting payment for services furnished to a recipient by the billing provider. Services provided are represented on the claim by HCPCS or other approved billing codes.

Crossover claims are defined as set out above, depending on the claim type submitted.

Provider Reimbursement Appeal Procedures

405 IAC 1-1.5-1 Scope
Authority: IC 12-15-21
Affected: IC 4-21.5-3

Sec. 1. (a) This rule governs the procedures for appeals to the office of Medicaid policy and planning (office) involving actions or determinations of reimbursement for all Medicaid providers.

(b) This rule governs the procedures for appeals to the office from the following actions or determinations:

(1) Setting rates of reimbursement.
(2) Any action based upon a final audit.
(3) Determination of change of provider status for purposes of setting a rate of reimbursement.
(4) Determination by the office that an overpayment to a provider has been made due to a year-end cost settlement.
(5) Any other determination by the office that a provider has been paid more than it was entitled to receive under any federal or state statute or regulation.
(6) The office's refusal to enter into a provider agreement.
(7) The office's suspension, termination, or refusal to renew an existing provider agreement.

(c) Notwithstanding subsections (a) and (b), this rule does not govern determinations by the office or its contractor with respect to the authorization or approval of Medicaid services requested by a provider on behalf of a recipient.

405 IAC 1-1.5-2 Appeal requests
Authority: IC 12-15-21
Affected: IC 4-21.5-3-7, IC 12-15-13-3

Sec. 2. (a) Appeals governed by this rule will be held in accordance with IC 4-21.5-3, except as specifically set out in this rule. The ultimate authority for purposes of this section is the secretary of family and social services administration, in accordance with IC 12-8-6-6.

(b) A request for an appeal must be filed within the following time limits:
(1) A request for an appeal of a determination that an overpayment has occurred must be filed within the time limits set out in IC 12-15-13-3.
(2) A hospital's request for an appeal of an action described in IC 4-21.5-3-6(a)(3) and (a)(4) must be filed within 180 days.

(3) All other appeal requests governed by this rule must be filed with the ultimate authority within fifteen (15) calendar days of receipt of the determination by the office of Medicaid policy and planning (office), in accordance with IC 4-21.5-3-7. However, any provider subject to administrative review or reconsideration under 405 IAC 1 must seek administrative review or reconsideration prior to filing an appeal request.

(c) An appeal request must state facts demonstrating that:

(1) the petitioner is a person to whom the order is specifically directed;

(2) the petitioner is aggrieved or adversely affected by the order; or

(3) the petitioner is entitled to review under any law.

Failure of the provider to file the appeal request within the time limits listed in subsection (b) will result in the waiver of any right to appeal from the office's determination.

(d) The provider must file with the office a statement of issues:

(1) within forty-five (45) calendar days after the provider receives notice of the determination of the office; or

(2) at the time the provider files a timely request for appeal; whichever is later.

(d) The statement of issues shall set out in detail:

(1) the specific findings, action, or determinations of the office from which the provider is appealing;

(2) with respect to each finding, action, or determination, why the provider believes that the office's determination was in error; and

(3) with respect to each finding, action, or determination, all statutes or rules supporting the provider's contentions of error.

(f) A hospital appealing an action described in IC 4-21.5-3-6 (a)(3) and (a)(4) must include its statement of issues in its petition for review.

(g) The statement of issues shall govern the scope of the issues to be adjudicated in the appeal under this rule. The provider will not be permitted to expand the appeal beyond the statement of issues with respect to:

(1) the specific findings, action, or determination of the office; or

(2) the reason or rationale supporting the provider's appeal.

(h) The provider may supplement or modify its statement of issues for good cause shown, up to sixty (60) calendar days after the appeal request is mailed to the office. The administrative law judge assigned to hear the appeal will determine good cause.

(i) Within thirty days after filing a petition for review, and upon a finding of good cause by the administrative law judge, a hospital appealing an action described in IC 4-21.5-3-6 (a)(3) and (a)(4) may amend the statement of issues contained in a petition for review to add one (1) or more additional issues.

(j) Failure of the provider to timely file a statement of issues within forty-five (45) calendar days from the date the provider files the appeal request will result in automatic certification to the secretary for summary review, in accordance with section 3 of this rule.

(k) Notwithstanding (d) and (e) of this section, a hospital provider that files an appeal after a determination regarding year-end cost settlement may preserve any Medicaid issues that are affected by any Medicare appeal issues, by indicating in its statement of issues that Medicare issues timely filed before the fiscal intermediary are also preserved in its Medicaid statement of issues.

405 IAC 1-1.5-3 Summary review
Authority: IC 12-15-21
Affected: IC 4-21.5-3

Sec. 3. (a) The office of Medicaid policy and planning (office) will provide a summary review by the secretary of family and social services administration (secretary) of certain issues set out in the provider's statement of issues. Issues in the provider's statement of issues that challenge the propriety of:

(1) all or part of the general methodology or criteria utilized by the office for setting rates;

(2) all or part of the general methodology or criteria utilized by the office with respect to any audits;

(3) all or part of the general methodology or criteria utilized by the office for making determinations with respect to change of provider status; and

(4) all or part of any other general methodology or criteria utilized by the office for making any determination set out in section 1(b) of this rule;

will be certified for summary review by the secretary.

(b) The office shall not certify for summary review any issue in which the provider challenges the application of the office's methodology or criteria in the provider's particular circumstances. Issues involving application of the office's methodology or criteria will be set for an evidentiary hearing under IC 4-21.5-3. The administrative law judge shall exclude any:

(1) evidence or argumentation on issues certified to the secretary, or

(2) issues not specifically enumerated in the provider's statement or amended statement of issues.

(c) For appeals filed before the effective date of this rule, the office may certify issues determined under subsection (a) to the secretary or the secretary's designee, according to the issues set out in the provider's appeal letter.

(d) There shall be no appeal from a determination by the office certifying any issues for summary review by the secretary.

405 IAC 1-1.5-4 Decision on summary review
Authority: IC 12-15-21
Affected: IC 4-21.5-3-28

Sec. 4. (a) Upon a determination of the office of Medicaid policy and planning (office) that any or all of the issues in the provider's statement of issues concern issues in section 3(a) of this rule, the office will certify to the secretary of family and social services administration (secretary) those issues for summary review by the secretary or the secretary's designee. With respect to each issue certified by the office, the secretary or the secretary's designee will issue a decision:

(1) affirming the determination of the office;

(2) dissolving the determination of the office; or

(3) remanding the determination of the office for an evidentiary hearing before an administrative law judge.

(b) The decision of the secretary or the secretary's designee on summary review shall be rendered within forty-five (45) calendar days after certification by the office to the secretary.

(c) The secretary shall send a notice of the decision on summary review to the provider. The decision on summary review of the secretary or the secretary's designee is interlocutory unless it adjudicates all the issues in the provider's appeal. It is not a final order until all issues in the provider's statement of issues are adjudicated by the secretary or the secretary's designee under IC 4-21.5-3-28. A provider may not seek judicial review of an adverse determination of the secretary on summary review until such time as a final order on all the issues in the provider's statement of issues is rendered.

405 IAC 1-1.5-5 Repayment of overpayment to Office
Authority: IC 12-15-21
Affected: IC 4-21.5-3; IC 24-4.6-1-101

Sec. 5. (a) The office of Medicaid policy and planning (office) may require the repayment of any amount determined by the office to have been paid to the provider in error, prior to an evidentiary hearing or summary review, unless an appeal is pending and the provider has elected not to repay an alleged overpayment pursuant to 405 IAC 1-1-5(d)(3). The office may, in its discretion, recoup any overpayment to the provider by the following means:

(1) Offset the amount of the overpayment against current Medicaid payments to a provider.

(2) In the case of an institutional provider, offset the amount of the overpayment to any or all of the Medicaid facilities owned by the provider, until the overpayment has been satisfied.

(3) Require that the provider satisfy the overpayment by refunding the entire amount of the overpayment to the office directly.

(4) Enter into an agreement with the provider in accordance with 405 IAC 1-1-5.

(b) Interest from the date of the overpayment will be assessed even if the provider repays the overpayment to the office within thirty (30) days after receipt of the notice of the overpayment. This subsection applies to any of the methods of recoupment set out in this section. Interest on overpayments shall not exceed the percentage set out in IC 12-15-13-3(f)(1).

(c) Notwithstanding any other rule in this article, for hospitals who receive a notice that the provider has been underpaid by the Office as a result of the cost settlement process, the Office will pay interest to the hospital on the amount of the underpayment. Such interest will accrue from the date of the underpayment at the rate of interest set out in IC 12-15-13-3 (f)(2).